Upland Unified School District School Phone # _____ School Fax # _____

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

This form must be completed before any medication *(prescription or* over-*the counter)* can be given, or taken, at school. ***Signatures* of *both physician* and *parent/guardian* are *required.* This *form* must be *renewed annually* or with *any change* in *medication. It will be automatically discontinued at the end of the school year. New orders are required each school year.***

Over the counter medications must be new, unopened with the student's name/date of birth on it.
All medications filled by a pharmacist must come with the pharmacy provided label; this includes self-carry inhalers, epi pens, etc.

Student Name: _____ **Date of Birth:** _____

PHYSICIAN USE ONLY

1. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: Oral Nasal Topical Stop date if a short term medication: _____
Inhale Injection Other _____

☐ If DAILY ~ Time(s) to be given: _____

☐ If AS NEEDED (prn)~ Frequency: ☐ Every 3 to 4 hrs., Every 4 to 6 hrs., ☐ Other : _____

☐ **Self carry for asthma inhaler or epinephrine auto injectors ONLY. Contract signed by parent and student.**

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

_____

2. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: Oral Nasal Topical Stop date if a short term medication: _____
Inhale Injection Other _____

☐ If DAILY ~ Time(s) to be given: _____

☐ If AS NEEDED (prn)~ Frequency: ☐ Every 3 to 4 hrs., Every 4 to 6 hrs., ☐ Other : _____

☐ **Self carry for asthma inhaler or epinephrine auto injectors ONLY. Contract signed by parent and student.**

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

_____

Physician Signature: _____ **Date:** _____
Physician Name: _____
Address: _____ **Phone:** _____
City: _____ **Zip:** _____

California Education Code section 49423 provides that any pupil who is required to take during the regular school day medication prescribed for him, by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

*California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto injectable epinephrine in a manner other than *as* prescribed.

Parent Request
For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication (prescription or over-the-counter) can be given or taken at school. **Signature of a parent or guardian is required. This form must be renewed each school year or with any change in medication.**

Student Name: _____ Date of Birth: _____

Parent Request for School Assistance with Medication
I understand that school district regulations require student medication to be maintained in a secure place under the direction of an adult employee of the school district and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions.) A. **I hereby request that the staff of my child's school assist in giving medication** to my child during school hours as stated in the physician instructions. I the undersigned give consent to the health office staff to contact the physician for clarification on these orders only. Parent or Guardian Signature: _____ Date: _____ Phone: _____ B. **For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR *SELF-CARRY* requests only:** I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication. I the undersigned give consent to the health office staff to contact physician for clarification on these orders only Parent or Guardian Signature: _____ Date: _____ Phone: _____

Student Contract - Asthma Inhalers and Epinephrine Auto-Injectors Only

I agree to keep my medication in a safe and secure place such as on my person at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day or several times a week I will speak with the school nurse.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

For UUSD office staff use only:
Medication_____
Date of Order __/__/_____

California Education Code section 49423 © A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.